Ministry of Health
Ontario

HEALTH CARE CONSENT ACT, 1996 SUMMARY

PURPOSE OF THE ACT

The *Health Care Consent Act, 1996* replaces the *Consent to Treatment Act, 1992*. Like the repealed *Consent to Treatment Act, 1992*, the *Health Care Consent Act, 1996* deals comprehensively with the issue of consent to health services. The Act clearly establishes the right of people in Ontario to make informed decisions about health treatment. The Act codifies all the elements of consent to health services in one piece of legislation, and applies to treatment provided in all settings by health practitioners specified in the Act.

The Act also provides a mechanism to obtain a treatment decision from a substitute decision maker for those who, at the time health treatment is required, are not mentally capable of consenting on their own behalf. As a safeguard, the legislation gives people the right to have a finding of mental incapacity reviewed.

The Act requires that wishes regarding treatment expressed by mentally capable people when at least 16 years of age be honoured should they become mentally incapable.

The *Health Care Consent Act, 1996* adds a substitute decision making framework for admission of incapable people to long-term care facilities and for decisions about personal assistance services (routine activities of living) for incapable people in such facilities and other places as set out in regulations.

COMPONENTS OF THE ACT

CONSENT TO HEALTH TREATMENT

Consent Requirement

Part II of the *Health Care Consent Act, 1996* in Part II codifies the requirement for obtaining a consent to health treatment and the necessary elements of a valid consent to treatment.

In order for consent to be valid, the person must be, in the opinion of the health practitioner who proposes the treatment, mentally capable to consent to that treatment.

If the health practitioner believes that the person is mentally incapable of consenting, the Act provides for a substitute decision maker to consent on the incapable person's behalf [s.10].

The consent sought by the health practitioner must relate to the proposed treatment and must be informed. The person must be provided with information about the treatment, the expected benefits, the material risks and side effects, alternative courses of action, and the likely consequences of not having the treatment that a reasonable person in the same circumstances would require in order to make a decision. The consent must be given voluntarily, must not be obtained through misrepresentation or fraud and can be withdrawn at any time by the person if he or she is capable, or by the substitute decision maker if the person is incapable. The consent may be expressly stated or implied [s.11].

Consent includes consent to variations or adjustments in the treatment if the nature, risks and benefits, material risks and side effects of the changed treatment are not significantly different from the original treatment.

Consent includes consent to the continuation of the same treatment in a different setting if the expected benefits, material risks and material side effects would not be significantly different as a result of the change in setting in which the treatment is administered [s.12].

Treatment Definition

Treatment continues to have a broad definition (anything done for a therapeutic, preventive, diagnostic, cosmetic or other health-related purpose). Certain exclusions are set out in the Act, for example, an assessment to determine the general nature of the person's condition or, any treatment that in the circumstances poses little or no risk of harm to the person [s.2(1)].

The Act allows a health practitioner to "opt in" to the provisions of the Act in order to obtain a consent for treatments that pose little or no risk of harm. Where a health practitioner decides to "opt in", the Act and the regulations apply as if the excluded act were a treatment within the definition of the Act [s.3].

Mental Capacity for Treatment Decisions

Under the *Health Care Consent Act, 1996*, a person is presumed to be capable of deciding about treatment unless it is unreasonable to presume so. A person of any age is capable with respect to a treatment if the person is able to understand the information relevant to making the decision about the treatment and able to appreciate the reasonably foreseeable consequences of a decision or lack of decision [s.4].

The determination of mental capacity with respect to treatment is specific to the treatment proposed. In other words, a person may be mentally capable of consenting to some treatments and not others, and may be mentally capable at some times and not others [ss.15(1),(2)].

The health practitioner proposing the treatment determines whether a person is mentally capable of making a decision about the treatment [s.10].

When a person is found incapable of consenting to treatment under the *Health Care Consent Act, 1996*, health practitioners are required to follow guidelines established by their governing bodies as to information to be provided to their patients about the consequences of findings of treatment incapacity [s.17].

A regulation under the *Mental Health Act* requires a rights adviser to meet with in-patients of those psychiatric facilities, that are governed by that Act who are found incapable of consenting to treatment of a mental disorder [s.15 of Regulation 741].

Consent on Mentally Incapable Person's Behalf

The *Health Care Consent Act, 1996* provides a framework for determining who may make a decision about health treatment on a mentally incapable person's behalf. In most cases, the closest family member serves as substitute decision maker. Under the *Substitute Decisions Act, 1992*, people will continue to be able, if they wish, to designate in advance, in a power of attorney for personal care, who should make treatment (and other) decisions on their behalf in case of future mental incapacity. The Public Guardian and Trustee is the substitute decision maker of last resort [s.20].

The *Health Care Consent Act, 1996* specifies the principles to be followed by substitute decision makers in making health treatment decisions on behalf of others. A person's most recent wishes about treatment, expressed when mentally capable and at least 16 years of age, must be followed by the substitute decision maker unless they are impossible to comply with. In the absence of such prior wishes, the substitute decision is to be based on the person's best interests in accordance with criteria in the Act [s.21].

The *Health Care Consent Act, 1996*, allows a health practitioner to apply to the Consent and Capacity Board if he or she thinks that a substitute decision maker who gave or refused consent to a treatment did not follow the rules for making substitute decisions [s.37].

Applications to the Consent and Capacity Board

A person who is the subject of the treatment and who is found to be mentally incapable by a health practitioner may apply to the Consent and Capacity Board for a review of the finding of mental incapacity (unless the person has a guardian of the person, if the guardian has authority to give or refuse consent to the treatment; or an attorney for personal care if the power of attorney contains a provision waiving the person's right to apply to the Board and the provision is effective under subsection 50(1) of the *Substitute Decisions Act, 1992*). The Board may either confirm the finding of incapacity or may determine that the person is mentally capable with respect to the treatment and, therefore, able to make his or her own treatment decision [s.32].

If there is a review before the Board or an

appeal to Court, treatment may not begin unless emergency treatment criteria are met [s.18(3)(d)(ii)].

Any party may appeal decisions of the Board to the Ontario Court, General Division. The Court may substitute its own decision for that of the health practitioner or for that of the Board, or refer the matter back to the Board for rehearing [s.80(10)].

In certain circumstances, where the case concerns a consent to treatment, the Court has the authority to authorize treatment pending the disposition of the appeal [s.19].

Emergency Treatment of Mentally Incapable Persons

Under the *Health Care Consent Act, 1996,* there is an emergency if the person for whom treatment is proposed is apparently experiencing severe suffering or is at risk, if the treatment is not administered promptly, of sustaining serious bodily harm [s.25(1)]

The Act provides for emergency treatment of a mentally incapable person without consent where a substitute decision cannot be obtained in time [s.25(2)].

However, a health practitioner cannot administer treatment if he or she is aware that the person, when mentally capable, expressed a wish applicable to the circumstances to refuse the treatment [s.26].

In addition, the *Health Care Consent Act, 1996* provides that emergency treatment without consent may be provided to a person who is apparently capable but the communication needed to get a consent or refusal cannot take place because of a language barrier or disability. Steps that are reasonable in the circumstances must be taken to find a way for the communication to take place and there must be no reason to believe that the person does not want the treatment [s.25(3)].

Where treatment is begun in such situations, the health practitioner must ensure that reasonable efforts are continued to find a substitute decision maker, or a means of communication [ss.25(6),(7),(8)].

Examinations, including diagnostic procedures, are also permitted without consent in order to determine whether an emergency exists, where consent cannot be obtained in time or finding a means of communication would put the person at risk [s.25(4)].

Protection from Liability

The Act provides certain protections from liability for health practitioners and substitute decision makers who act in good faith and in accordance with the Act [ss.29;30;31].

ADMISSION TO CARE FACILITIES

Part III of the Act sets out a streamlined framework for substitute decision making for admission of incapable people to "care facilities" (nursing homes, homes for the aged, and any other facilities which may be added by regulation) [ss.2(1);40(1)].

This framework is similar to the one for treatment set out in Part II of the Act. It provides for substitute decision making, a right of review for findings of incapacity and other applications to the Board, crisis admission, and liability protection.

A person is presumed to be capable of deciding about admission to a care facility unless it is unreasonable to presume so. A person of any age is capable with respect to admission to a care facility if the person is

able to understand the information relevant to making the decision about the admission to a care facility and able to appreciate the reasonable foreseeable consequences of a decision or lack of decision [s.4].

When a decision concerns admission to a care facility, mental capacity is determined by an "evaluator" (audiologist, speech-language pathologist, nurse, occupational therapist, physician, physiotherapist, psychologist, or social worker) [ss.2(1); 40(1)]. Such capacity determinations are arranged by placement coordination services as part of the long-term care admission process.

Rights information is to be provided to a person who is found incapable of consenting to admission to a long-term care facility, by policy of the Ministry of Health, Long-Term Care Division.

PERSONAL ASSISTANCE SERVICES

Part IV of the Act sets out a new substitute decision making framework for decisions about personal assistance services for incapable recipients of these services (similar to the one for treatment). "Personal assistance service" means assistance with or supervision of hygiene, washing, dressing, grooming, eating, drinking, elimination, ambulation, positioning or any other routine activity [ss.2(1);56].

Part IV applies in long-term care facilities (nursing homes and homes for the aged) and such other places as may be added by regulation [ss.2(1);85(1)(e)].

The application of this part of the Act is at the discretion of the service provider [s.57(1)]. For example, a service provider may choose to seek a formal substitute consent under this Act where an incapable nursing home resident's routine care is very difficult to manage.

A person is presumed to be capable of deciding about personal assistance services unless it is unreasonable to presume so. A person of any age is capable with respect to a personal assistance service if the person is able to understand the information relevant to making the decision about the personal assistance service and able to appreciate the reasonable foreseeable consequences of a decision or lack of decision [s.4].

When a decision concerns a personal assistance service, mental capacity is determined by an "evaluator" (audiologist, speech-language pathologist, nurse, occupational therapist, physician, physiotherapist, psychologist, or social worker) [ss.2(1);57(1)].

For the purposes of Part IV, the Public Guardian and Trustee has the discretion whether or not to serve as substitute decision maker [s.58].

MISCELLANEOUS

The Act sets out offences for substitute decision makers who knowingly make false assertions, misrepresent wishes and make decisions contrary to a person's wishes with respect to decisions about treatment, admission to a care facility or personal assistance services [ss.82;83;84]

In case of a conflicting provision between the *Health Care Consent Act, 1996* and the *Child and Family Services Act*, the provision of the *Child and Family Services Act* prevails for one year from the date that the *Health Care Consent Act, 1996* comes into force [s.86].

If you have any questions about the *Health Care Consent Act, 1996,* please contact:

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